STATE OF MICHIGAN

DEPARTMENT OF LABOR & ECONOMIC GROWTH

OFFICE OF FINANCIAL AND INSURANCE REGULATION

Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXX
Petitioner **File No. 88559-001**

v

Blue Cross Blue Shield of Michigan
Respondent
_____/

Issued and entered
This 9th day of September 2008
by Ken Ross
Commissioner

ORDER

I
PROCEDURAL BACKGROUND

On March 17, 2008, XXXXX (Petitioner), filed a request for external review with the Commissioner of the Office of Financial and Insurance Regulation under the Patient's Right to Independent Review Act, MCL § 550.1901 *et seq.* The Commissioner reviewed the material submitted and accepted the request on March 24, 2008.

The issue in this external review can be decided by contractual analysis. The contract here is the Community Blue Group Benefits Certificate (the certificate) as amended by the BCBSM Rider CNM Certified Nurse Midwife (the rider). The Commissioner reviews contractual issues pursuant to MCL 550.1911(7). The Commissioner did not request a medical opinion from an independent review organization.

II
FACTUAL BACKGROUND

From June 6, 2006, to January 27, 2007, the Petitioner received maternity services (pre-natal care, vaginal delivery, and postpartum care) at the XXXXX Birth Center (XXXXX) from

XXXXX, a certified nurse midwife (CNM). The total charges in question are $3,600.00. BCBSM denied payment for this care. XXXXX and XXXXX do not participate with BCBSM.

The Petitioner appealed BCBSM's denial. BCBSM held a managerial-level conference on January 7, 2008, and issued a final adverse determination dated January 14, 2008, confirming its denial of coverage.

III
ISSUE

Did BCBSM correctly deny coverage for the Petitioner's care provided by a CNM at XXXXX?

IV
ANALYSIS

Petitioner's Argument

On January 16, 2007, the Petitioner gave birth at XXXXX assisted by XXXXX. The Petitioner paid the $1,500.00 charge for vaginal delivery. However, she believes that BCBSM is required to pay the $2,100.00 charge for pre-natal and post-natal care. The Petitioner argues that according to the rider, pre-natal and post-natal care is covered when provided by a CNM and that XXXXX is a CNM.

The Petitioner contends that on April 24, 2006, she telephoned BCBSM customer service and was told that XXXXX was a participating provider and that her services would be covered by BCBSM at 80% after the deductible was met. It was not until the Petitioner submitted the $3,600.00 bill for the care that she was told that it would not be covered.

The Petitioner also argues that Michigan law (MCL 500.3406r) requires that obstetrical and gynecological services be covered when performed by a physician or nurse midwife acting within the scope of his or her license or specialty certification. Based on this law and the language of the rider, the Petitioner believes that she is entitled to be reimbursed at least for the pre- and post-natal care provided by XXXXX.

BCBSM's Argument

Under the terms of the rider, BCBSM pays its approved amount for CNM services. However, BCBSM says the services must be provided in an inpatient hospital setting or in a birthing center that is hospital affiliated, state licensed, accredited, and approved by BCBSM. In addition, the certificate limits coverage in nonparticipating facilities to the treatment of accidental injuries or medical emergencies.

In the Petitioner's case, she received all pre- and post- natal services from a CNM but they were provided at (and billed by) XXXXX as facility charges. Since this birth center is not hospital affiliated and does not participate with BCBSM, BCBSM says the claims were denied appropriately.

BCBSM also disputes the Petitioner's assertion that its customer service representatives told her that her care by the CNM would be covered. BCBSM says its records indicate that the Petitioner was told that the CNM had to be registered with BCBSM. BCBSM also says it contacted XXXXXX and was told that XXXXX informs its patients up front that they are a private pay provider and do not submit claims to BCBSM.

BCBSM maintains that it acted properly when it denied payment for the care provided to the Petitioner at XXXXX.

Commissioner's Review

The rider to the Petitioner's certificate states in pertinent part:

> **II. SERVICES WHICH ARE PAYABLE**
>
> We pay the approved amount for the following services when provided by a Certified Nurse Midwife:
> - Normal vaginal delivery when provided in:
>   1. an inpatient hospital setting or
>   2. a birthing center which is hospital affiliated, state licensed and accredited as defined and approved by BCBSM.
> - Pre-natal care.
> - Post-natal care, including a Papanicolau (PAP) smear during the six week visit.

III. HOW CNM SERVICES ARE PAID

We pay the approved amount for each covered service. Your copayment and/or deductible, if applicable, is subtracted from the approved amount before we make our payment.

- Participating CNM
  You will not be required to pay any remaining difference between the approved amount and the billed charge for covered services obtained from participating CNM's. These providers have agreed to accept BCBSM approved amounts as payment in full.
- Non-participating CNM
  In addition to any applicable deductible and/or copayments, you will be required to pay the difference between the BCBSM approved amount and the non-participating CNM charge for covered services. Non-participating CNM's have not agreed to accept our approved amounts as payment in full.

Section 3 of the certificate, *Coverage for Hospital, Facility and Alternative to Hospital Care,* states in pertinent part:

- If the provider is nonparticipating you will need to pay most of the charges yourself. Your bill could be substantial because BCBSM coverage at nonparticipating hospitals is limited to services needed to treat an accidental injury or medical emergency.

The rider language is clear that for a normal vaginal delivery by a CNM to be a covered benefit it must be provided in an inpatient hospital setting or at a hospital-affiliated birthing center approved by BCBSM. Since XXXXX does not meet these requirements, the Petitioner's delivery is not a covered benefit. The Petitioner has implicitly acknowledged this because she paid the $1,500.00 delivery charge and asked in her request for external review that BCBSM cover the cost of her pre- and post-natal care.

In this case there is no dispute that XXXXX is a CNM. There is nothing in the rider that requires where pre- and post–natal care by a CNM is to be provided or how it must be billed. The only requirement in the rider is that a CNM provide the care. It can be provided by either a participating or non-participating provider. The rider explains how services performed by nonparticipating CNMs are paid and further warns that the Petitioner will have to pay any

difference between BCBSM's approved amount and the nonparticipating CNM's charge for covered services.

BCBSM argues that since XXXXX, a nonparticipating facility, billed for the pre- and post-natal care, it is not a covered benefit, and BCBSM cites language in the certificate that says, "[C]overage at nonparticipating hospitals is limited to services needed to treat an accidental injury or medical emergency." However, XXXXX is not a hospital so this language does not apply. Further, neither BCBSM nor the Petitioner included the actual claim in the record, and the Commissioner cannot assume that pre- and post-natal services had been billed as anything other than the CNM services that were performed.

The Commissioner finds under the terms of the certificate and rider, any medically necessary covered pre-natal and post-natal maternity care the Petitioner's received from a CNM is a covered benefit.

V
ORDER

Respondent BCBSM's final adverse determination of January 14, 2008, is reversed in part. BCBSM is required to provide coverage at its approved amount for any medically necessary covered pre-natal and post-natal services provided to the Petitioner by XXXXX, CNM, subject to any deductible, copayment, coinsurance, or other applicable condition of the certificate. BCBSM shall provide coverage with 60 days and provide proof of coverage to the Commissioner within seven days after coverage is provided.

This is a final decision of an administrative agency. Under MCL § 550.1915, any person aggrieved by this Order may seek judicial review no later than sixty days from the date of this Order in the circuit court for the county where the covered person resides or in the circuit court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of the Office of Financial and Insurance Regulation, Health Plans Division, Post Office Box

30220, Lansing, MI 48909-7720.